CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Policy and Operations

(Amendment)

907 KAR 10:016. Coverage provisions and requirements regarding inpatient psychiatric hospital services.

RELATES TO: KRS 205.520

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 C.F.R. 441 Subparts C, D, 456 Subparts G, H, I, 42 U.S.C. 1396a-d[~~, EO 2004-726~~]

NECESSITY, FUNCTION, AND CONFORMITY: [~~EO 2004-726, effective July 9, 2004, reorganized the Cabinet for Health Services and placed the Department for Medicaid Services and the Medicaid Program under the Cabinet for Health and Family Services.~~] The Cabinet for Health and Family Services has responsibility to administer the Medicaid Program[~~of Medical Assistance~~]. KRS 205.520(3) authorizes[~~empowers~~] the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds[~~for the provision of medical assistance to Kentucky's indigent citizenry~~]. This administrative regulation establishes[~~sets forth~~] the Medicaid Program coverage provisions and requirements regarding inpatient [~~relating to~~] services provided by[~~in~~] psychiatric hospitals[~~for which payment shall be made by the Medicaid Program in behalf of both the categorically needy and the medically needy~~].

Section 1. Definitions. (1) "Active treatment" means a covered psychiatric hospital service provided:

(a) In accordance with 42 C.F.R. 441.154; and

(b) By professional staff employed or contracted by a psychiatric hospital.

(2) "Chronic" is defined by KRS 210.005(3).

(3) "Department" means the Department for Medicaid Services or its designee.

(4) "Enrollee" means a recipient who is enrolled with a managed care organization.

(5) "Federal financial participation" is defined by 42 C.F.R. 400.203.

(6) "Interdisciplinary team" means:

(a) For a recipient who is under the age of eighteen (18) years:

1. A parent, legal guardian, or caregiver of the recipient;

2. The recipient;

3. Professional staff; and

4. A staff person, if available, who worked with the recipient during the recipient's most recent placement if the recipient has previously been in a psychiatric hospital; or

(b) For a recipient who is eighteen (18) years of age or older:

1. The recipient;

2. Professional staff; and

3. A staff person, if available, who worked with the recipient during the recipient's most recent placement if the recipient has previously been in a psychiatric hospital.

(7) "Managed care organization" means an entity for which the Department for Medicaid Services has contracted to serve as a managed care organization as defined in 42 C.F.R. 438.2.

(8) "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(9) "Mental illness" is defined by KRS 210.005(2).

(10) "Professional staff" means psychiatrists and other physicians, psychologists, psychiatric nurses and other nurses, social workers, and other professionals with special education or experience in the care of persons with mental illness and who are involved in the diagnosis and treatment of patients with mental illness.

(11) "Recipient" is defined by KRS 205.8451(9).

Section 2. General Provider Participation Requirements. (1) To be eligible to provide services covered under this administrative regulation, a psychiatric hospital shall:

(a) Be currently enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672;

(b) Except as established in subsection (2) of this section, be currently participating in the Kentucky Medicaid Program in accordance with 907 KAR 1:671;

(c) Be licensed as a psychiatric hospital in accordance with 902 KAR 20:180;

(d) Meet the facility specification requirements established in 902 KAR 20:170;

(e) Have a utilization review plan for each recipient;

(f) Establish a utilization review process which shall evaluate each Medicaid admission and continued stay prior to the expiration of the Medicaid certification period to determine if the admission or stay is or remains medically necessary;

(g) Be located within the Commonwealth of Kentucky;

(h) Perform and place in each recipient's record a:

1. Medical evaluation;

2. Social evaluation; and

3. Psychiatric evaluation; and

(i) Establish a plan of care for each recipient which shall:

1. Address in detail the intensive treatment services to be provided to the recipient;

2. Be placed in the recipient's record; and

3. Meet the master treatment plan requirements established in 902 KAR 20:180; and

(j) If providing services to an individual who is at least sixty-five (65) years of age, be currently certified for participation in the Medicare program.

(2) In accordance with 907 KAR 17:015, Section 3(3), a psychiatric hospital which provides a service to an enrollee shall not be required to be currently participating in the fee-for-service Medicaid Program.

(3) A psychiatric hospital shall:

(a) Agree to provide services in compliance with federal and state laws regardless of age, sex, race, creed, religion, national origin, handicap, or disability;

(b) Comply with the Americans with Disabilities Act (42 U.S.C. 12101 et seq.) and any amendments to the Act; and

(c) Comply with:

1. 907 KAR 1:671;

2. 907 KAR 1:672; and

3. All applicable state and federal laws.

(4)(a) A psychiatric hospital attests by the psychiatric hospital's staff's or representative's signature that any claim associated with a service is valid and submitted in good faith.

(b) Any claim and substantiating record associated with a service shall be subject to audit by the:

1. Department or its designee;

2. Cabinet for Health and Family Services, Office of Inspector General or its designee;

3. Kentucky Office of Attorney General or its designee;

4. Kentucky Office of the Auditor for Public Accounts or its designee;

5. United States General Accounting Office or its designee; or

6. For an enrollee, managed care organization in which the enrollee is enrolled.

(c) If a psychiatric hospital receives a request from the:

1. Department to provide a claim, related information, related documentation, or record for auditing purposes, the psychiatric hospital shall provide the requested information to the department within the timeframe requested by the department; or

2. Managed care organization in which an enrollee is enrolled to provide a claim, related information, related documentation, or record for auditing purposes, the psychiatric hospital shall provide the requested information to the managed care organization within the timeframe requested by the managed care organization.

(d)1. All services provided shall be subject to review for recipient or provider abuse.

2. Willful abuse by a psychiatric hospital provider shall result in the suspension or termination of the psychiatric hospital from Medicaid Program participation.

Section 3. Coverage Requirements. (1) For the department or managed care organization to reimburse for a service covered under this administrative regulation, the service shall be:

(a) Medically necessary; and

(b) Provided:

1. To a recipient:

a.(i) Who is at least sixty-five (65) years of age and requires inpatient psychiatric services; or

(ii) Who is under twenty-one (21) years of age and requires inpatient psychiatric services; and

b. Whose needs require inpatient psychiatric hospital services:

(i) On a daily basis; and

(ii) Under the direction of a physician; and

2. By professional staff of a psychiatric hospital that meets the requirements established in this administrative regulation.

(2) Inpatient psychiatric hospital services shall involve active treatment that shall be reasonably expected to:

(a) Improve the recipient's condition; or

(b) Prevent further regression.

(3) If a recipient is receiving inpatient psychiatric hospital services on the recipient's twenty-first (21st) birthday, the Medicaid Program shall continue to cover the recipient's admission:

(a) As long as the services continue to be medically necessary for the recipient; and

(b) Through the birth month in which the child becomes twenty-one (21) years of age.

(4)(a) If a recipient is eligible for Medicare coverage of inpatient psychiatric services, the

recipient shall exhaust all Medicare coverage of inpatient psychiatric services prior to being eligible for Medicaid coverage of inpatient psychiatric services.

(b) After exhausting Medicare coverage of inpatient psychiatric services, the department, or managed care organization for an enrollee, shall determine if a continued stay in a psychiatric hospital:

1. Is medically necessary for the recipient; and

2. Can be reasonably expected to:

a. Improve the recipient's condition; or

b. Prevent further regression.

(5) The requirements established in 42 C.F.R. 456, Subpart D, shall apply regarding Medicaid program coverage of inpatient psychiatric hospital services.

Section 2. KRS 202A Related Admission.[[~~Provision of Service. Inpatient services provided in an appropriately licensed psychiatric hospital participating in the Medicaid program shall be limited to recipients of medical assistance age sixty-five (65) or over or under age twenty-one (21) meeting patient status criteria. Services shall be provided in accordance with the federal Medicaid requirements and with Medicaid policies shown in the Psychiatric Inpatient Facility Utilization and Placement Review Manual, revised December 28, 1994 which is hereby incorporated by reference and referred to hereafter as "the manual". The manual may be reviewed during regular working hours (8 a.m. to 4:30 p.m.) in the Office of the Commissioner, Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621. Copies may also be obtained from that office upon payment of an appropriate fee which shall not exceed approximate cost.~~

~~Section 2. Durational Limitation. Durational limitation on payment in respect to the~~

~~aged recipient and children under age twenty-one (21) shall be subject to the utilization review mechanism established by the cabinet and shown in the manual. Notwithstanding a continuing need for psychiatric care, payment for services shall not be continued past the 22nd birthday for patients admitted prior to the 21st birthday.~~

~~Section 3. Condition of Eligibility for Participation. An appropriately accredited psychiatric hospital desiring to participate in the Medicaid program shall be required as a condition of eligibility to participate in the Medicare program when the hospital serves patients eligible for payments under the Medicare program.~~

~~Section 4. Determining Patient Status. Professional staff of the cabinet or an agency operating under its lawful authority pursuant to the terms of its agreement with the cabinet shall review and evaluate the health status and care needs of a[the] recipient in need of psychiatric hospital care giving consideration to the medical diagnosis, care needs, services and health personnel required to meet the needs, and ambulatory care services available in the community to meet those needs.~~

~~(1) The patient shall not qualify for Medicaid patient status unless:~~

~~(a) The person is qualified for admission, and continued stay as appropriate;~~

~~(b) Their needs mandate psychiatric hospital care on a daily basis; and~~

~~(c) As a practical matter, The necessary care can only be provided on an inpatient basis.~~

~~(2) The placement and continued stay criteria shown in Parts II, III and IV of the Manual shall be used to:~~

~~(a) Determine patient status;~~

~~(b) Ensure that proper treatment of the individual's psychiatric conditions requires ser-~~

~~vices on an inpatient basis under the direction of a physician;~~

~~(c) Ensure that psychiatric hospital services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed, or;~~]

(1) For an adult who is at least [~~chronically mentally ill adults age~~] sixty-five (65) years of age, has chronic mental illness, and is[~~and above as described in KRS 210.005, who are~~] admitted to a psychiatric hospital[~~the~~] hospital under a KRS Chapter 202A commitment, the psychiatric hospital shall maintain the recipient at, or restore him to, the greatest possible degree of health and independent functioning.

(2) [~~;~~]; For a recipient who was at least[~~individuals age~~] sixty-five (65) years of age and [~~or over~~] residing in a psychiatric hospital on December 28, 1994, the requirement for admission under a commitment pursuant to KRS Chapter 202A shall not apply[~~be applicable~~] if:

(a) The recipient[~~individual~~] continues to reside in the same psychiatric hospital; and

(b)[~~(d) Ensure that~~] Ambulatory care or alternative services available in the community are not sufficient to meet the treatment needs of the recipient.

Section 3.[~~5.~~] Reevaluation of Need for Services. (1)(a) A psychiatric[~~All mental~~] hospital stay[~~stays~~] shall be certified for a specific length of time[~~,~~] as deemed medically appropriate by the:

1. Department for a recipient who is not an enrollee; or

2. Managed care organization in which an enrollee is enrolled, if applicable.

(b) In determining the appropriate length of time for a stay, the department or a managed care organization shall consider [~~utilization review organization considering~~] the

health status and care needs of the individual[~~applicant or recipient~~].

(2)(a) A recipient's continued eligibility for inpatient psychiatric hospital services [~~Patient status~~] shall be reevaluated at least once every thirty (30) days.

(b) Upon the expiration of a[~~the~~] certified length of stay, the Medicaid Program shall not be responsible for the cost of care of a continuing stay unless the recipient or the recipient's[~~his~~] authorized representative:

1. Requests a continuing stay; and

2. The:

a. Department approves the continued stay; or

b. For an enrollee, managed care organization in which the enrollee is enrolled approves the continued stay[~~the utilization review organization certifies additional days~~].

Section 4. Other Limitations and Exclusions. (1) An admission for diagnostic purposes shall only be covered if the diagnostic procedure cannot be performed on an outpatient basis.

(2) The Medicaid Program shall not reimburse for any day in which a recipient is not present in the psychiatric hospital.

(3) The Medicaid Program shall not reimburse for a court-ordered psychiatric hospital admission unless the department determines that the admission meets the criteria established in Section 3(1) of this administrative regulation.

(4) The Medicaid Program shall not reimburse for:

(a) An elective admission; or

(b) An admission for substance use treatment.

Section 5. Records Maintenance. (1)(a) For each recipient, a psychiatric hospital shall

maintain a health record that shall:

1. Be:

a. Current;

b. Readily retrievable;

c. Organized;

d. Complete; and

e. Legible;

2. Meet the record requirements established in

a. 902 KAR 20:180;

b. KRS 194A.060;

c. KRS 434.840 through 860;

d. KRS 422.317; and

e. 42 CFR 431 Subpart F;

3. Document the need for admission and appropriate utilization of services;

4. Be maintained, including information regarding payments claimed, for a minimum of six (6) years or until an audit dispute or issue is resolved, whichever is longer; and

5. Be made available for inspection or copying or provided to the following upon request:

a. A representative of the United States Department for Health and Human Services or its designee;

b. The United States Office of the Attorney General or its designee;

c. The Commonwealth of Kentucky, Office of the Attorney General or its designee;

d. The Commonwealth of Kentucky, Office of the Auditor of Public Accounts or its

designee;

e. The Commonwealth of Kentucky, Cabinet for Health and Family Services, Office of the Inspector General or its designee;

f. The department; or

g. Personnel of the managed care organization in which the recipient is enrolled if applicable;

6. Contain a:

a. Physician's certification statement documenting the medical necessity of the recipient's:

(i) Admission to the psychiatric hospital; and

(ii) If applicable, continued stay in the psychiatric hospital; and

b. Copy of the recipient's most recent plan of care that:

(i) Has been established and approved by the recipient's physician; and

(ii) Shall include the date of the most recent interdisciplinary team review or revision of the plan of care;

c. Copy of the Medicare remittance advice of explanation of Medicare benefits if the recipient has Medicare coverage for inpatient psychiatric services; and

d. Copy of any Medicare denial letters if applicable.

(b) A physician's certification statement shall:

1. Be made no earlier than sixty (60) days prior to the recipient's admission to the psychiatric hospital; or

2. Not be made prior to the individual applying for Medicaid benefits while in an institutional setting.

(c) A licensed staff or consulting physician shall sign and date a certification statement.

(b) Failure to provide information in accordance with paragraph (a) of this subsection shall result in denial of payment for any service associated with the requested information.

(2) For each recipient, a psychiatric hospital shall have a physician's certification statement documenting the necessity of the psychiatric hospital admission.

(3) If a recipient is transferred or referred to a health care facility or other provider for care or treatment, the psychiatric hospital shall, within ten (10) business days of awareness of the transfer or referral, transfer the recipient's records in a manner that complies with the records' use and disclosure requirements as established in or required by:

(a)1. The Health Insurance Portability and Accountability Act;

2. 42 U.S.C. 1320d-2 to 1320d-8; and

3. 45 C.F.R. Parts 160 and 164; or

(b)1. 42 U.S.C. 290ee-3; and

2. 42 C.F.R. Part 2.

(4)(a) Except as established in paragraph (b) or (c) of this subsection, a psychiatric hospital shall maintain a case record regarding a recipient for at least six (6) years from the last date of the service or until any audit dispute or issue is resolved beyond six (6) years.

(b) After a recipient's death or discharge from services, a psychiatric hospital shall maintain the recipient's record for the longest of the following periods:

1. Six (6) years unless the recipient is a minor; or

2. If the recipient is a minor, three (3) years after the recipient reaches the age of majority under state law.

(c) If the Secretary of the United States Department of Health and Human Services requires a longer document retention period than the period referenced in paragraph (a) of this subsection, pursuant to 42 C.F.R. 431.17 the period established by the secretary shall be the required period.

(5)(a) A psychiatric hospital shall comply with 45 C.F.R. Part 164.

(b) All information contained in a case record shall:

1. Be treated as confidential;

2. Not be disclosed to an unauthorized individual.

Section 6. Auditing Authority. The department or the managed care organization in which an enrolled is enrolled shall have the authority to audit any:

(1) Claim;

(2) Medical record; or

(3) Documentation associated with any claim or medical record.

Section 7. Federal Approval and Federal Financial Participation. The Medicaid Program's coverage of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the coverage; and

(2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 8. [~~Reconsideration and~~] Appeals. (1) An appeal of an adverse action by the department regarding a service and a recipient who is not enrolled with a managed care organization shall be in accordance with 907 KAR 1:563.

(2) An appeal of an adverse action by a managed care organization regarding a service and an enrollee shall be in accordance with 907 KAR 17:010[~~When an adverse determination is appealed by the applicant or recipient, the decision shall be reviewed by the cabinet (or its representative) using time frames specified in the manual to determine whether the decision should be reversed.~~

~~Section 7. Implementation Date. The amendments to this administrative regulation shall be effective with regard to services provided on or after December 28, 1994~~].

907 KAR 10:016

REVIEWED:

3.25.15
Date

Lisa Lee, Commissioner
Department for Medicaid Services

APPROVED:

4/9/15
Date

Audrey Tayse Haynes, Secretary
Cabinet for Health and Family Services

907 KAR 10:016

PUBLIC HEARING AND PUBLIC COMMENT PERIOD

A public hearing on this administrative regulation shall, if requested, be held on May 22, 2015 at 9:00 a.m. in the Health Services Auditorium, Suite B, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky, 40621. Individuals interested in attending this hearing shall notify this agency in writing by May 15, 2015 five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. The hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation. You may submit written comments regarding this proposed administrative regulation until close of business June 1, 2015. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, KY 40601, Phone: (502) 564-7905, Fax: (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation: 907 KAR 10:016
Contact person: Stuart Owen (502) 564-4321

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the Department for Medicaid Services' (DMS's) coverage provisions and requirements regarding inpatient services provided in a psychiatric hospital.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish DMS's coverage provisions and requirements regarding regarding inpatient services provided in a psychiatric hospital.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing DMS's coverage provisions and requirements regarding inpatient services provided in a psychiatric hospital.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the authorizing statutes by establishing DMS's coverage provisions and requirements regarding inpatient services provided in a psychiatric hospital.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: The amendment clarifies that this administrative regulation applies to inpatient services provided by a psychiatric hospital; inserts provisions previously stated in material that was incorporated by reference; inserts records maintenance requirements; establishes that DMS's coverage of psychiatric hospital services pursuant to this administrative regulation is contingent upon federal funding and federal approval; eliminates the incorporated material; and contains language and formatting revisions to comply with current KRS Chapter 13A standards.

(b) The necessity of the amendment to this administrative regulation: The amendment is necessary to clarify that the requirements of the administrative regulation only apply to inpatient psychiatric hospital services as DMS is concurrently promulgating two (2) new administrative regulations that establish Medicaid program coverage of outpatient psychiatric hospital services. Additionally, the amendment is necessary to eliminate old incorporated material that contained archaic language; insert records maintenance requirements; and insert language ensuring that coverage of services is contingent upon federal funding and federal approval.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by clarifying the scope of the administrative regulation's applicability as well as ensuring that coverage of the services is contingent upon federal funding and approval.

(d) How the amendment will assist in the effective administration of the statutes: The amendment will assist in the effective administration of the authorizing statutes by clarifying the scope of the administrative regulation's applicability as well as ensuring that

coverage of the services is contingent upon federal funding and approval.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Psychiatric hospitals will be affected by the amendment. Currently, there are twelve (12) psychiatric hospitals enrolled in the Medicaid Program.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment. No action is required.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). No cost is anticipated.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). The entities referenced in paragraph (a) will benefit due to clarify.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: DMS will incur no initial costs as a result of the amendment.

(b) On a continuing basis: DMS will incur no continuing cost as a result of the amendment.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under the Social Security Act, Title XIX and matching funds of general fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment. Neither an increase in fees nor funding is necessary to implement this administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation neither establishes nor increases any fees.

(9) Tiering: Is tiering applied? Tiering is not applied as the policies apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

Administrative Regulation: 907 KAR 10:016
Contact person: Stuart Owen (502) 564-4321

1. Federal statute or regulation constituting the federal mandate. 42 USC 1396a(a)(10), 42 USC 1396d(a)(16), 42 USC 1396d(h), 42 CFR 441.151 and 42 CFR 440.160.

2. State compliance standards. To qualify as a psychiatric hospital, a facility must meet the licensure requirements established in 902 KAR 20:180.

3. Minimum or uniform standards contained in the federal mandate. Per federal Medicaid law, inpatient psychiatric facility services for individuals under twenty-one (21) is not a mandatory Medicaid benefit, but if a state's state plan includes intermediate care facility services for individuals with mental retardation, it must also cover inpatient psychiatric facility services for individuals under twenty –one 21.) Additionally, states may be required to provide inpatient psychiatric care under the early and periodic screening, diagnosis and treatment program (EPSDT).

Pursuant to 42 CFR 440.160, ""Inpatient psychiatric services for individuals under age 21" means services that—
(a) Are provided under the direction of a physician;
(b) Are provided by—
(1) A psychiatric hospital or an inpatient psychiatric program in a hospital, accredited by the Joint Commission on Accreditation of Healthcare Organizations, or
(2) A psychiatric facility which is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Council on Accreditation of Services for Families and Children, the Commission on Accreditation of Rehabilitation Facilities, or by any other accrediting organization, with comparable standards, that is recognized by the State.
(c) Meet the requirements in §441.151 of this subchapter."

Additionally, 42 CFR 441.151 states, "(a) Inpatient psychiatric services for individuals under age 21 must be:
(1) Provided under the direction of a physician;
(2) Provided by—
(i) A psychiatric hospital or an inpatient psychiatric program in a hospital, accredited by the Joint Commission on Accreditation of Healthcare Organizations; or
(ii) A psychiatric facility that is not a hospital and is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children, or by any other accrediting organization with comparable standards that is recognized by the State.
(3) Provided before the individual reaches age 21, or, if the individual was receiving the services immediately before he or she reached age 21, before the earlier of the following—
(i) The date the individual no longer requires the services; or

(ii) The date the individual reaches 22; and
(4) Certified in writing to be necessary in the setting in which the services will be provided (or are being provided in emergency circumstances) in accordance with §441.152.
(b) Inpatient psychiatric services furnished in a psychiatric residential treatment facility as defined in §483.352 of this chapter, must satisfy all requirements in subpart G of part 483 of this chapter governing the use of restraint and seclusion."

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? The administrative regulation does not impose stricter than federal requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. The administrative regulation does not impose stricter than federal requirements.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Administrative Regulation: 907 KAR 10:016
Contact person: Stuart Owen (502) 564-4321

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services will be affected by the amendment to this administrative regulation.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 194A.030(2), 194A.050(1), 205.520(3).

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? The amendment is not expected to generate revenue for state or local government.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? The amendment is not expected to generate revenue for state or local government.

(c) How much will it cost to administer this program for the first year? DMS will incur no costs for the first year as a result of the amendment.

(d) How much will it cost to administer this program for subsequent years? DMS will incur no costs for subsequent years as a result of the amendment.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):
Expenditures (+/-):
Other Explanation: